AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		mhl026-654	B. WING	B. WING		15/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GRACEL	AND MANOR DDA #1		VFIELD DRIVE EVILLE, NC 28	301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	An annual survey w 2022. Deficiencies	vas completed on March 15, were cited.				
	category: 10A NCA	sed for the following service C .5600C Supervised Living elopmental Disabilities.				
		sed for 6 and currently has a urvey sample consisted of clients.				
V 112	27G .0205 (C-D) Assessment/Treatn	nent/Habilitation Plan	V 112			
	PLAN (c) The plan shall b assessment, and in legally responsible of admission for clie receive services be (d) The plan shall i (1) client outcome(ILITATION OR SERVICE to developed based on the to partnership with the client or person or both, within 30 days ents who are expected to syond 30 days.				
	 projected date of ac (2) strategies; (3) staff responsible (4) a schedule for annually in consultar responsible person 	chievement; le; review of the plan at least ation with the client or legally or both; ation or assessment of				
	(6) written consent responsible party, c	or agreement by the client or or a written statement by the y such consent could not be				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		mhl026-654	B. WING		03/15/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	IATE, ZIP CODE		
GRACEL	AND MANOR DDA #	1	VFIELD DRIVE EVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 112	Continued From pa	age 1	V 112			
	Based on record re facility failed to dev based on assessm and failed to obtain for the treatment/ha	et as evidenced by: eviews and interviews the elop and implement strategies ent affecting 1 of 4 clients (#3) written consent or agreement abilitation or service plan by ible person for 1 or 4 clients are:				
	revealed: -51 year old female -Admitted on 6/28/ -Diagnoses of Schi Intellectual Disabilit					
	treatment plan reve -PCP completed or -Signature page ind for the PCP was th (PSR) Qualified Pro	n 7/15/21. dicated the person responsible e Psychosocial Rehabilitation ofessional (QP). als or strategies identified for				
	-She attended a da	facility for almost 3 years.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		mhl026-654	B. WING		03/	15/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GRACEL	AND MANOR DDA #1		VFIELD DRIVE EVILLE, NC 28			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 112	Continued From pa	ge 2	V 112			
	revealed: -44 year old male. -Admitted on 5/1/03	lectual Disability, Asthma,				
	treatment plan reve -Treatment plan co -Signature page sig signed by QP/Licer -No documentation	mpleted on 5/28/21. jn by legal guardian on 5/5/18,				
	Interview on 3/9/22 -He lived at the fac -His father was his	ility over 20 years.				
	stated: -She had complete goals and strategie -She was unable to client #3.	locate the treatment plans for locate the signature page for				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	only be administered					

STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		mhl026-654	B. WING		03/	15/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
GRACEL	AND MANOR DDA #1		FIELD DRIVE			
		FAYETTE	VILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 3	V 118			
	clients only when au client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medications recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for a (D) date and time th (E) name or initials drug. (5) Client requests to checks shall be reco	Ill be self-administered by uthorized in writing by the sluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. ministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug; ne drug is administered; and of person administering the for medication changes or orded and kept with the MAR appointment or consultation				
	interviews the facilit were administered of physician and MAR	et as evidenced by: views, observations, and y failed to ensure medications on the written order of a s were kept current for 4 of 4 and #4). The findings are:				
		3/15/22 of client #1's record				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		mhl026-654	B. WING		03/15/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
GRACEL	AND MANOR DDA #1					
			EVILLE, NC 28			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	age 4	V 118			
	-66 year old female.-Admitted on 1/15/94.-Diagnoses of Psychotic Disorder and Moderate Intellectual Disability.					
	physician orders re -10/31/21: Polyethy ounces of water da : Diclofenac S to affected area top for joint pain. -12/16/21: Olmesar daily. (high blood p	vlene Glycol 3350, 1 cap into 8 ily as needed for constipation. odium 1% Gel, apply 4 grams bically 4 times daily as needed rtan Medoxomil 40 mg tablet ressure) n 1 mg (milligram) daily at				
	from November 20. -Prazosin 1 mg was administered for the -Diclofenac Sodium on November MAR -Olmesartan Medo	3/15/22 of client #1's MARs 21 to January 2022 revealed: s not documented as e month of January. n 1% Gel was not transcribed to xomil 40 mg was not ministered daily in January.				
	client #1;s medicati -Polyethylene Glyco	ol 3350, Olmesartan and Diclofenac Sodium 1% Ge				
	Attempted interviev revealed she was r	v on 3/7/22 with client #1 non-verbal.				
	Finding #2 Review on 3/7/22 - revealed: -57 year old male. -Admitted on 1/31/0	3/15/22 of client #2's record				

STATE FORM

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	mhl026-654	B. WING		03/	15/2022
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
AND MANOR DDA #1					
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 5	V 118			
 -Diagnoses of Schizophrenia paranoid, Mild Intellectual Disability, Hypertension, Diabetic Mentotense, Seizure Disorder and Allergic Rhinitis. Review on 3/7/22 - 3/15/22 of client #2's signed physician orders revealed: 2/11/21: clotrimazole-betamethasone 1% topical cream, apply twice daily. (fungal infections) 11/1/21: Divalproex Sodium Extended Release 500 mg, 1 tablet every morning and 2 tablets at bedtime. (seizure) 11/11/21: Trazodone 150 mg tablet at bedtime. (depression) 					
from November 202 -clotrimazole-betan and Trazodone 150	21 to January 2022 revealed: nethasone 1% topical cream) mg were not documented as				
of client #2's medic -Divalproex Sodium	ations revealed: n Extended Release 500 mg				
revealed: -51 year old female -Admitted on 6/28/ -Diagnoses of Schi Intellectual Disabilit	e. 19. zophrenia Disorder, ty Mild, Breast Cancer, Kidney				
	OF CORRECTION PROVIDER OR SUPPLIER AND MANOR DDA # SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa -Diagnoses of Schi Intellectual Disabilit Mentotense, Seizur Rhinitis. Review on 3/7/22 - physician orders re 2/11/21: clotrimazo cream, apply twice 11/1/21: Divalproex 500 mg, 1 tablet ev bedtime. (seizure) 11/11/21: Trazodon (depression) Review on 3/7/22 - from November 20 -clotrimazole-betan and Trazodone 150 administered in De Observation on 3/7 of client #2's medic -Divalproex Sodium was not available fo Interview on 3/7/22 - revealed: -51 year old female -Admitted on 6/28/ ² -Diagnoses of Schi Intellectual Disabilit Failure, Microcytic J	OF CORRECTION IDENTIFICATION NUMBER: mhl026-654 PROVIDER OR SUPPLIER STREET A 600 DOW FAYETTI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 -Diagnoses of Schizophrenia paranoid, Mild Intellectual Disability, Hypertension, Diabetic Mentotense, Seizure Disorder and Allergic Rhinitis. Review on 3/7/22 - 3/15/22 of client #2's signed physician orders revealed: 2/11/21: clotrimazole-betamethasone 1% topical cream, apply twice daily. (fungal infections) 11/11/21: Divalproex Sodium Extended Release 500 mg, 1 tablet every morning and 2 tablets at bedtime. (seizure) 11/11/21: Trazodone 150 mg tablet at bedtime. (depression) Review on 3/7/22 - 3/15/22 of client #2's MARs from November 2021 to January 2022 revealed: -clotrimazole-betamethasone 1% topical cream and Trazodone 150 mg were not documented as administered in December. Observation on 3/7/22 between 3:45pm - 4:00pm of client #2's medications revealed: -Divalproex Sodium Extended Release 500 mg was not available for review on 3/7/22. Interview on 3/7/22 client #2 stated: -He received his medications daily. Finding #3 Review on 3/7/22 - 3/15/22 of client #3's record revealed: -51 year old female. -Admitted on 6/28/19. -Diagnoses of Schizophrenia Disorder, Intellectual Disability Mild, Breast Cancer, Kidney Failure, Microcytic Anemia and Diabetes Mellitlus	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: mhl026-654 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AND MANOR DDA #1 600 DOWFIELD DRIVE FAYETTEVILLE, NC 28301 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAST BE PRECEDENCIES) REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDENT TAG PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY Continued From page 5 V 118 V118 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY Continued From page 5 V 118 V118 DEFICIENCY Continued From page 5 V 118 V118 -Diagnoses of Schizophrenia paranoid, Mild Intellectual Disability, Hypertension, Diabetic Mentotense, Seizure Disorder and Allergic Rhinitis. V118 Review on 3/7/22 - 3/15/22 of client #2's signed physician orders revealed: 2/11/21: clotrimazole-betamethasone 1% topical cream, apply twice daily. (fungal infections) 11/11/21: Trazodone 150 mg tablet at bedtime. (depression) Review on 3/7/22 - 3/15/22 of client #2's MARs from November 2021 to January 2022 revealed: -clotrimazole-betamethasone 1% topical cream and Trazodone 150 mg were not documented as administered in December. Observation on 3/7/22 between 3:45pm - 4:00pm of client #2's medications revealed: -Divalproex Sodium Extended Release 500 mg was not available for review on 3/7/22. Interview on 3/7/22 client #2 stated: -He received his medications daily. Interview on 3/7	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM mhi026-654 B. WING 037 PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE AND MANOR DDA #1 600 DOWFIELD DRIVE FAYETTEVILLE, NC 28301 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LG: DIENTIFYING INFORMATION) ID PREFX PROVIDER'S PLAN OF CORRECTION ACID BE (EACH ORRECTIVE ADDRIVE/WIST BE PRECEDED BY FULL REGULATORY ON LG: DIENTIFYING INFORMATION) PREFX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 5 V 118 PREVENT OF DESTORE and Allergic Rhinitis. V 118 DEFICIENCY Continued From page 5 V 118 V 118 DEFICIENCY Conditionationacide-betamethasone 1% topical cream, apply twice daily. (fungal infections) 111/1121: Divalprove Socium Extended Release 500 mg, 1 tablet every morning and 2 tablets at bedtime. (seizure) 111/11/21: Trazodone 150 mg tablet at bedtime. (depression) Review on 3/7/22 - 3/15/22 of client #2's MARs from November 2021 to January 2022 revealed: -Otvinaproce-betamethasone 1% topical cream and Trazodone 150 mg were not documented as administered in December. Diservient #2's tablet: -Divalproce Sodium Extended Release 500 mg was not available for review on 3/7/22. Interview on 3/7/22 of client #3's record revealed: -Divalproce Sodium Extended Release 500 mg was not available for review on 3/7/22. Interview on 3/7/22 of client #3's record revealed: -51 year old female. -Admitted on 6/28/19. -Diagnoses of Schizophre

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		- (X3) DATE SURVEY COMPLETED - 03/15/2022	
		mhl026-654				
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GRACEL	AND MANOR DDA #1		FIELD DRIVE	301		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 118	Continued From pa	ge 6	V 118			
	daily. (indigestion) 7/13/21: Ferrous Subreakfast. (iron) 11/2/21: Benztropin (Parkinson's) Clozapine 100 and 4 tablets at bed Haloperidol 20 (schizophrenia) Docusate Sodi needed. (laxative) Oxycodone - A 10-325 1 every 6 hd 11/5/21: Lisinopril 5 Loratadine 10 12/29/21: Metronida and apply to breast dressing changes.	n Oxide 400 mg tablet twice ulfate 325 mg 1 daily with e Mesylate 0.5mg at bedtime. mg 2 tablets every morning ltime. (mental/mood) mg twice daily. um 100 mg 1 capsules as acetaminophen (Oxyco-APAP) ours for moderate pain. mg 1 daily. (blood pressure) mg 1 daily. (allergy) azote 500mg crush 2 tablets 3 times per week with				
	from November 202 -Benztropine Mesyl 12/31/21. -Clozapine 100 mg 12/31/21. -Haloperidol 20 mg	3/15/22 of client #3's MARs 21 to January 2022 revealed: ate 0.5mg blank on 12/26/21 - blank on 12/27/21 (7pm) - blank on 12/27/21 (7pm) -				
	12/31/21. -Lisinopril 5 mg blar -Loratadine 10 mg l -Magnesium Oxide administered in Nov	5 mg blank on 12/28/21 - nk on 12/28/21 - 12/31/21. blank on 12/28/21 - 12/31/21. 400 mg not documented as /ember. 25 was administered 4 times a				

Division of Health Service STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		mhl026-654	B. WING		03/15/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GRACEL	AND MANOR DDA #1		VFIELD DRIVE EVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 7	V 118			
	administered. -Fentanyl 12 mcg/h for December and n Observation on 3/9, of client #3's medic - Docusate Sodium onsite for review. Interview on 3/9/22 -She received her r -She knew what me -She had received breast about 3 time Finding #4 Review on 3/7/22 - revealed: -44 year old male. -Admitted on 5/1/03 -Diagnoses of Intell	100 mg was not available client #3 stated: nedications daily. edications she took. Metronidazote 500mg on her as a week. 3/15/22 of client #4's record 3. lectual Disability, Asthma,				
	physician orders re 4/28/21: Phentermi suppressant) 11/10/21: Trazodon bedtime. (depressio :Topiramate 20 (seizure) 1/4/22: Triamterene daily. (edema) : Vitamin D3 (supplement) Review on 3/7/22 - from November 202	3/15/22 of client #4's signed vealed: ne 37.5 mg daily. (appetite e HCL 150 mg 1/2 tablet at				

STATE FORM

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		mhl026-654	B. WING		00/45/0000	
				03/	03/15/2022	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ /FIELD DRIVE			
GRACEL	AND MANOR DDA #1		EVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	ge 8	V 118			
	administered on the following dates 11/1/21, 11/2/21, 12/1/21-12/10/21, 1/1/22-1/10/22. -Trazodone HCL 150 mg and Topiramate 200 mg were not transcribed on the December MAR. -Triamterene HCTZ 37.5 - 25 mg and Vitamin D3 1000 unit were not transcribed on the January MAR.					
	of client #4's medic -Phentermine 37.5	mg, Triamterene HCTZ 37.5 - D3 1000 unit were not				
	Interview on 3/9/22 -He took his medica					
	technician stated: -Phentermine 37.5 and should not had -Some of the medic filled in months for -She requested the	2 the local pharmacy mg was last filled on 4/28/21 been available for client #4. cations were had not been client #1, #2, #3, and #4. Qualified Professional et discontinue orders to s from the MAR.				
	-Client #1 received -She was unsure w documented on the on the MAR while a -The QP/Licensee kept at the office. -She and staff #1 w	made copies of the MARs and vere the only ones to				
	medication was adr -Client #1's Polyeth	the MARs each time after				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		mhl026-654	B. WING		02/45/2022		
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	03/15/2022	
		600 DOV	FIELD DRIVE				
RACEL	AND MANOR DDA #1	FAYETTE	EVILLE, NC 28	3301			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From pa	ge 9	V 118				
	available for review -Client #2 took his la 3/7/22. -Client #2's Divalpro pharmacy on 3/9/22 -She made a note for medications not ava -The client's receive medications often b not get it. -Client #4's Phenter discontinued and do had not received it s -She believed the N from the ones she a -The clients receive ordered and had no Interview on 3/7/22 stated:	ast Divalproex the morning of bex was delivered by the 2. or the Licensee of all ailable onsite to order. ed their as needed but if it is not marked they did					
	medications as orde -She made copies of to locate the complet facility. -She would ensure						
V 121	27G .0209 (F) Medi	ication Requirements	V 121				
	governing body or c						

E STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		mhl026-654	B. WING		03/15/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GRACEL	AND MANOR DDA #	1	VFIELD DRIVE EVILLE, NC 28			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
TAG			TAG	DEFICIENC		
V 121	Continued From pa	age 10	V 121			
	shall be to be perfor physician. The on-s the client's physicia the review when m (2) The findings of	very six months. The review ormed by a pharmacist or site manager shall assure that an is informed of the results of edical intervention is indicated the drug regimen review shall client record along with applicable.				
	Based on record re failed to perform siz regimens of clients	et as evidenced by: eviews and interview the facility x-month reviews of the drug receiving psychotropic ing 4 of 4 clients (#1, #2, #3 gs are:	/			
	revealed: -66 year old female -Admitted on 1/15/9 -Diagnoses of Psyc Intellectual Disabilit	94. chotic Disorder and Moderate				
	regimen revealed: -Loratadine 10 milli (allergy) -Pravastatin Sodiur (cholesterol) -Prazosin 1 mg tab pressure)	of client #1's daily drug igram (mg) tablet daily. m 40 mg tablet at bedtime. let at bedtime. (high blood ded Release (ER) 60 mg table ressure)	t			

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		mhl026-654	B. WING		03/15/2022		
	PROVIDER OR SUPPLIER		r ADDRESS, CITY, STATE, ZIP CODE				
		600 DOW	FIELD DRIVE				
GRACE	LAND MANOR DDA #1		VILLE, NC 28	301			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 121	Continued From pa	ge 11	V 121				
	(mental/mood) -Risperidone 3 mg f -Vitamin D 5000 tak -Alphagan P 0.1% I medication) -Cyclobenzaprine 5 needed. (muscle pa -Alendronate Sodiu (osteoporosis) -Amantadine 100 m (Parkinson's) -Aspirin EC 81 mg 2 -Benztropine mesyl (Parkinson's) -Clonazepam 0.5mg -Divalproex Sodium (seizure) -Docusate Sodium (constipation) -Escitalopram 20 m -Fluticasone Propio sprays daily. (allerg -Olopatadine 0.2 % daily. -Multivitamin Time 0 tablet daily. (supple -Naproxen 500 mg (pain) -Polyethylene Glyco constipation. -Diclofenac Sodium joint pain. -Olmesartan Medox blood pressure) Finding #2	blet daily. (supplement) Drops twice daily. (glaucoma mg table twice daily as ain) m 35 mg tablet weekly. Ing tablet twice daily. 2 tablets daily. (pain) ate 1 mg tablet twice daily. g tablet twice daily. (seizure) a 250 mg 2 tablets twice daily. 100mg tablets twice daily. g tablet daily. (depression) nate 50 microgram (mcg) 2 y) Eye Itch Relief drops once Compensated Gain (TCG)					

STATE FORM

					E SURVEY PLETED	
	mhl026-654		B. WING		03/	15/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		10/2022
GRACEL	AND MANOR DDA #1	600 DOW	FIELD DRIVE VILLE, NC 28			
	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 121	Continued From pa	ge 12	V 121			
	Intellectual Disabilit Mentotense, Seizur Rhinitis. -No documentation drug review. Review on 3/18/22 regimen revealed: -Clotrim-Betametha area twice daily. (fu -Senna Plus Tablet (constipation) -Amlodipine Besyla blood pressure) -Atenolol 100mg tal pressure) -Benztropine Mes 1 -Colchicine 0.6 mg -Divalproex Sodium morning and 2 at be -Furosemide 20 mg -Lisinopril 40 mg ta pressure) -Loratadine 10 mg -Metformin (hydrocl with dinner. (type 2 -Paroxetine 40 mg (depression) -Perseris ER 120 mg	zophrenia paranoid, Mild y, Hypertension, Diabetic e Disorder and Allergic of a six-month psychotropic of client #2's daily drug asone topically to the affected ingal infection) 1 or 2 as needed. te 10 mg tablet daily. (high blet daily. (high blood mg tablet twice daily. (high blet daily. (high blood mg tablet twice daily. (gout) n 500 mg 1 tablet in the edtime. g tablet daily. (fluid retention) blet daily. (high blood tablet daily. (high blood tablet daily. (fluid retention) blet daily. (high blood tablet daily. (schizophrenia) ate 300 mg tablet at bedtime.				
	-Rosuvastatin Calci (cholesterol) Finding #3	ium 40 mg tablet daily.				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	mhl026-654		B. WING				
					03/	15/2022	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
RACEL	AND MANOR DDA #1		VFIELD DRIVE EVILLE, NC 28				
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
V 121	Continued From pa	ge 13	V 121				
	Review on 3/7/22 - revealed:	3/15/22 of client #3's record					
	-51 year old female -Admitted on 6/28/1						
		zophrenia Disorder,					
	Intellectual Disabilit	Intellectual Disability Mild, Breast Cancer, Kidney					
	Failure, Microcytic Anemia and Diabetes Mellitlus Type II.						
		-No documentation of a six-month psychotropic					
	drug review.						
		Review on 3/18/22 of client #3's daily drug					
	regimen revealed:	regimen revealed: -Trazodone HCL 100 mg 2 tablets at bedtime.					
	-Trazodone HCL 100 mg 2 tablets at bedtime. -Benztropine Mesylate 0.5mg tablet at bedtime.						
	-Clozapine 100 mg	2 tablets every morning and 4					
	tablets at bedtime.						
	-Haloperidol 20 mg (schizophrenia)	tablet twice dally.					
		5 mg tablet with breakfast.					
	(iron supplement)						
	-Lisinopril 5 mg tab -Loratadine 10 mg t						
		0 mg tablets twice daily.					
	-Multivitamin TCG ((Daily-Vite) tablet daily.					
		5 1 tablet every 6 hours as					
	needed for modera	um 40 mg tablet daily. (acid					
	reflux)						
		trength Mint Liquid 12 oz 3					
		times daily. (indigestion)					
	-Ibuprofen 800 mg tablet every 8 hours as needed. (pain)						
	-Non-Aspirin 325 m	-Non-Aspirin 325 mg 2 tablets every 6 hours as					
	needed for mild pai						
	 Magnesium Oxide (indigestion) 	400 mg tablet twice daily.					
		olet daily. (supplement)					
	-Fentanyl 12 mcg/h	our patch 1 patch every 3					
	days. (pain)						

			(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		mhl026-654	B. WING		03/	15/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GRACEL	AND MANOR DDA #1		FIELD DRIVE VILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 121	Continued From pa	ge 14	V 121			
	(infection) -Dronabinol 2.5 mg (appetite) -Capecitabine 500 i	mg 2 tablets 3 times a week. capsule tablet twice daily. mg chemo tab 3 tablets twice lowed by 7 days off. (breast				
	revealed: -44 year old male. -Admitted on 5/1/03 -Diagnoses of Intell Brain Ameroyta and	ectual Disability, Asthma,				
	regimen revealed: -Trazodone HCL 15 -Fluoxetine HCL 10 morning. (antidepre -Topiramate 200 mg -Levalbuterol 45 mg needed. (asthma) -Amlodipine Besyla blood pressure) -Montelukast SOD (allergy/asthma) -Symbicort 160 - 4.4 (asthma) -Triamterene - Hydr tablet daily. (edema	g 1 tablet at 5pm. (seizure) cg 1 puff every 4 hours as te 10 mg 1 tablet daily. (high 10 mg tablet daily. 5 mcg 1 puff twice daily. rochlorothiazide 37.5-25 mg				
		Professional stated: y care physician completed				

STATEME	of Health Service Re NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		mhl026-654	B. WING		03/	15/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GRACE	LAND MANOR DDA #1	600 DOW	FIELD DRIVE			
		FAYETTE	VILLE, NC 28	3301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 121	Continued From pa	ge 15	V 121			
		locate the most recent 6 n reviews for the clients.				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of co present at all times premises, except w habilitation plan doo capable of remainir without supervision as needed but not I the client continues the home or commi- specified periods of (c) Staff shall be pr following client-staff child or adolescent (1) children or abuse disorders sh of one staff present clients present. Ho present during slee emergency back-up the governing body (2) children or developmental disa one staff present fo present and two staff more clients present during clients present during slee	bes above the minimum in Paragraphs (b), (c) and (d) a determined by the facility to ond to individualized client one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ng in the home or community . The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for f time. resent in a facility in the f ratios when more than one client is present: r adolescents with substance all be served with a minimum f or every five or fewer minor pwever, only one staff need be ping hours if specified by the p procedures determined by ; or r adolescents with bilities shall be served with r every one to three clients aff present for every four or nt. However, only one staff ring sleeping hours if ergency back-up procedures				

			CONSTRUCTION		E SURVEY PLETED	
		mhl026-654	B. WING		03/	15/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	AND MANOR DDA #1	600 DOW	FIELD DRIVE			
		FAYETTE	VILLE, NC 28	301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From pa	ge 16	V 290			
	diagnosis is substan (1) at least or duty shall be trained withdrawal sympton secondary complica drug addiction; and (2) the servic	es of a certified substance all be available on an				
	interviews, the facili ratios above the min	views, observation, and ty failed to ensure staff-client nimum number to enable staff dualized client needs affecting				
	revealed: -66 year old female -Admitted on 1/15/9 -Diagnoses of Psyc Intellectual Disabilit	4. hotic Disorder and Moderate y. ıpports I need:Requires 1:1				
	during onsite surve	t #4 present at the facility. the facility.				
		group home since 2006. ift from 8:30am to 5pm.				

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		mhl026-654		B. WING		15/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	• • •	
GRACEL	AND MANOR DDA #1		FIELD DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 290	Continued From pa	ge 17	V 290			
	 -Client #1 received one services. -Other clients were supposed to provid -She was responsit home. Interview on 3/7/22 Licensee/Qualified -Client #1 received -Client #1 had rece while. -Staff #2 provided of #1. -She understood ad 	ble for all clients while at group				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a saf	303 LOCATION AND IREMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive				
	was not maintained and orderly manner Observation on 1/2 12:15pm of the outs	ion and interview, the facility I in a safe, clean, attractive				

	ivision of Health Service Regulation TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					-	
		mhl026-654	B. WING		03/	15/2022
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GRACEL	AND MANOR DDA #1		VFIELD DRIVE EVILLE, NC 28	301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 736	Continued From pa	ge 18	V 736			
	approximately every -The middle window cracked the length Observation on 3/7/ -11:30am during tou -The sound of a sm approximately every -The laminate floorid bathroom was folder near the bathtub. -A brown colored lini- inches wide across -There was duck ta the back bathroom. -The back right bed the window seal. -The cracked window	v near the driveway was of the bottom pane. /22 between 10:35am ut of the facility revealed: oke detector chirping y 2 minutes. ng in client #2 and client #3's ed back in a triangle shape ne about 2 feet long and 2 the ceiling in the dining area. pe over the light/fan switch in				
	-The smoke detector continued to chirp. -She had not notice -She would ensure	- 3/15/22 the Professional stated: or battery was replaced and ed other identified areas. facility was maintained in a we and orderly manner.				
V 738	EXTERIOR REQUI	03 LOCATION AND	V 738			

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	mhl026-654		B. WING			4 5 10 0 0 0
					03/	15/2022
NAME OF I	PROVIDER OR SUPPLIER		.DDRESS, CITY, ST VFIELD DRIVE			
GRACEL	AND MANOR DDA #1		EVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 738	Continued From pa	ge 19	V 738	DEFICIENC		
	facility free of insec Review on 1/24/22 Service Regulation -During a survey on observed at the fac	s the facility did not keep the ts. The findings are: of the Division of Health facility's record revealed: n 8/11/21 the bedbugs were ility.				
	records revealed: -An invoice from a l 11/11/21 for "Bed B -An invoice from a l 12/2/21 for "Bed Bu	and 3/7/22 of the facility ocal exterminator dated ug Service." ocal exterminator dated ig Service." ocal exterminator dated				
	couple months ago -He was bitten by th	his room around his bed a				
	the problem. -She does not know bedbugs.					
	sitting area and in the	on the couch in the client				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	mhl026-654		B. WING		03/	15/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	AND MANOR DDA #	600 DOV	VFIELD DRIVE			
SRACEL		FAYETTI	EVILLE, NC 28	8301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 738	Continued From pa	age 20	V 738			
	-She had not seen -The facility had be months. -The Qualified Prof previously had a m bedbugs.	en by bedbugs at the facility. a client with bedbug bites. d bugs appropriately 6 ressional (QP)/Licensee had an treating the facility for reated the facility for bedbugs.				
	-The closet and dre because of persona -They recommende and treated on 12/2 -There was heavy i bedroom, front righ couch on 11/11/21. -They normally reco heavy infestation. -No treatment was 3/7/22 -There was no evid treatment. -The facility "really	manager stated: eated on 11/11/21 and 12/2/21. easer couldn't be sprayed al items. ed a follow up after 10 days 2/21. nfestation in the back right t bedroom and behind the ommended 3 treatments for scheduled after 12/2/21. lence of live bedbugs at last				
	stated: -A local exterminate -They found bedbu -She needed to rec again. -She had schedule -The exterminator f and 1 live one." -She had not schedule	2 - 3/15/22 the QP/Licensee or treated the facility. gs behind the chair. juest the facility be treated d an appointment for 2/9/22. found "a couple of dead ones duled another appointment. nd in the bedroom near the				

Division	of Health Service Re	egulation				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		mhl026-654	B. WING		03/1	5/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		. 600 DOW	FIELD DRIV	E		
GRACEL	AND MANOR DDA #1	FAYETTE	VILLE, NC 2	28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 738	Continued From pa	ige 21	V 738			
	-	-				
	dining room on the					
		le another appointment for				
	treatment.	anneintreent en 2/1/22				
	-Sne scheduled an	appointment on 3/1/22. nad not found any bedbugs.				
	-The exterminator r	lad not lound any bedbugs.				
Division of H	ealth Service Regulation					